Field Treatment

1. Basic airway
2. Oxygen/Pulse oximetry/Assist respirations – **avoid hyperventilation** ①
3. Cardiac monitor/document rhythm and attach EKG/ECG strip
4. Shock position prn
5. Venous access prn

SINUS TACHYCARDIA
Rate <220 - INFANTS
Rate <180 - CHILDREN

6. Perfusing - reassess for potential deterioration

   Poor perfusion - fluid challenge 20ml/kg

7. Continually reassess respirations and pulses

SVT (Narrow Complex)
Rate >220 - INFANTS
Rate >180 - CHILDREN

6. **Adenosine 0.1mg/kg** IVP ❶ ❷ ❸

7. If no conversion – may repeat one time ❹ ❺

Note: If poor perfusion – may repeat one time **if it does not delay cardioversion** ❹ ❺

8. Consider sedation in the awake patient prior to cardioversion **Midazolam 0.1 mg/kg** IVP/IM/IN titrated to sedation ❻

9. Synchronized cardio-version two times (0.5 -1J/kg, 2J/kg) ② ③

10. Continually reassess respirations and pulses

V-TACH (Wide Complex)

6. If poor perfusion - consider sedation in the awake patient prior to cardioversion **Midazolam 0.1 mg/kg** IVP/IM/IN titrated to sedation ❻

7. Synchronized cardioversion up to four times (0.5, 1, 2, 4J/kg) ② ③ ④

8. Continually reassess respirations and pulses

Drug Considerations

Adenosine:

❶ Pediatrics: maximum first dose 6mg

❷ Immediately follow with rapid flush of 10-20ml NS.

❸ Contraindications:
- ✔ 2nd degree HB or 3rd degree HB
- ✔ On Persantine or Tegretol
- ✔ History of Sick Sinus Syndrome

❹ May repeat 0.2mg/kg IVP one time in 1-2 minutes

❺ Pediatrics: maximum second dose: 12 mg

See Color Code Drug Doses/ L.A. County Kids

Midazolam:

❻ May repeat every 3 -5 minutes to maximum total pediatric dose of 5mg

See Color Code Drug Doses/ L.A. County Kids

Special Considerations

① If BVM, use "squeeze-release-release" technique

② For failure to convert or transient conversion to NSR, consider transport

③ Monophasic or biphasic

④ If monitor does not discharge on "synch", turn off synch and shock